Exhibit G- Professional Notes from Beth Israel Deaconess Medical Center

Beth Israel Deaconess Medical Center/Healthcare Associates
General Medicine/Primary Care
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 1

Date: 01/05/00 Signed: 02/29/00 Cosigned: 03/01/00

FERNANDEZ,SONIA AGE 34
UNIT # 0023145

Not on any medications before January 5, 2000.

No medications DC'd on January 5, 2000.

Medications prescribed on January 5, 2000:

14 Exhibit

CELEXA 20MG--One by mouth every day
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and every needed for anxiety

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Patient seen initially ~1 year ago, now returns with the chief complaint of panic attacks.

1) Panic attacks - Patient notes onset every day at this point over the last 2 weeks and 1-2x/week prior of feeling of overwhelming panic. Arrives without trigger, characterized by feeling of flushing heat, tachycardia, tachypnea. Patient unable to function with attacks. Relieved over 1-2 hours time with rest, fresh air.

Patient has noted persistent sad mood, no anhedonia, some decreased appetite and weight loss to 98.4 lbs at today's visit. No guilty feelings. No change in concentration. Sleep disturbance not changed with Remuron.

Patient denies suicidal ideation, suicidal attempt, notes stressors of increased work and boyfriend. Patient denies any physical abuse with boyfriend, but emotionally manipulative. Patient does have supportive friends network with whom she has confided in throughout this time.

Physical Exam:
BP: 90/60. Asymptomatic.
HEENT: Moist mucous membranes, no lesions.
Neck: No adenopathy. Thyroid normal size w/o bruits.
Lungs clear to auscultation.
Heart: Regular with no murmurs.
Abdomen: NABS. NT, ND.

Summary:

34 y.o. female with increased stressors and symptoms characteristic of panic attacks.

Plan:

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Date: 01/05/00 Signed: 02/29/00 Cosigned: 03/01/00

AGE 34

FERNANDEZ,SONIA UNIT # 0023145

1) PANIC ATTACKS

Discussed extensively role of current emotional triggers and the importance of maintenance of supportive network. Patient to be started on Celexa 20 mg po q day at this visit. Will provide Klonopin .5 q h.s. and prn once per day for panic attack.

Patient to return in 1 week's time for evaluation of improvement on current therapies.

2) GYN

Patient is cared for endometriosis at outside clinic. To continue care there.

3) FATIGUE

Patient notes persistent low energy and fatigue. No increased somnolence. No evidence of snoring or obstructive sleep apnea of concern. Normal TSH, mild anemia noted in the past. Will f/u in improvement there with improved therapy for panic disorder.

4) HEADACHES

Patient to f/u in Neurology clinic as previously arranged.

GEOFFREY S. GILMARTIN, MD

Cosignature: GILA KRIEGEL, M.D.

[SOURCE: OMR]

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PROGRESS NOTE Page 1

Date: 01/19/00 Signed: 02/29/00 Cosigned: 03/01/00

FERNANDEZ,SONIA AGE 34
UNIT # 0023145

Medications before January 19, 2000:

CELEXA 20MG--One by mouth every day
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and every day as needed for anxiety

No medications DC'd on January 19, 2000.

No medications prescribed on January 19, 2000.

Routine visit for this 34 y.o. female.

Anxiety - Patient has not taken Celexa. Has used Klonopin with good relief each evening with decrease in severity of attacks but still occurring each day. Patient has had decreased po intake.

Continued stressors present with the boyfriend and work, but more manageable at this point per patient report.

Exam:
Wt: 95.4.

Summary:

34 y.o. female with panic attacks.

PANIC ATTACKS

Asked patient to agree to start Celexa therapy q day. To start today and will f/u in 1 week's time by phone for improved results.

Patient to use Klonopin q h.s. and as needed. Patient counseled not to drive while taking above medication. Further therapy to be dictated by response to Celexa and will f/u with patient in 1 week's time.

Patient concerned about inability to gain weight and will continue discussion in light of improvement or worsening of psychiatric symptoms

GEOFFREY S. GILMARTIN, MD

Cosignature: GILA KRIEGEL, M.D.

[SOURCE: OMR]

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General Medicine/Primary Care
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 1

Date: 04/19/00 Signed: 05/01/00 Cosigned: 05/12/00
AGE 34
FERNANDEZ,SONIA UNIT # 0023145

Medications before April 19, 2000:

CELEXA 20MG--One by mouth every day
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and every day as needed for anxiety

Medications DC'd on April 19, 2000:

CELEXA 20MG--

Medications prescribed on April 19, 2000:

MEGACE 20MG--One by mouth every day

VS: Wt. 95.8 lbs

Active Issues-

1)Weight Loss-Patient with continued poor po intake. Has refused nutrition referal stating she understands her limited po intake and its contribution but does not have appetite to eat more. Conservative measures have failed and depression treatment limited to psychoterapy and Klonopin for sleep. Discussed Megace at today's visit.

2)Depression/Anxiety-Klonopin providing patient with ability to sleep. Denies SI/HI. Feels that she is improving cirucumstances at work and home with more assertive approach. Has made attempts to contact therapist to whom she was refered.

EXAM-
Wt=95.8, BP=100/60
HEENT-Op wnl
NECK-No bruit, thyroid wnl
Lungs-CTA
Heart-Reg, no murmurs
Abd-NT/ND
Ext-No edema

A/P-34 yo female to be managed as follows

DEPRESSION/ANXIETY-Refuses further SSRi therapy, feels she is overall improved in terms of sleep and panic attacks with minimal Klonopin use and no concern for addiciton at this time
-Klonopin PRN for now
-Therapist referal made and patient to follow up
-Importance of this stressed to patient
-Patient agreed to call immediately with any change in

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Date: 04/19/00 Signed: 05/01/00 Cosigned: 05/12/00

FERNANDEZ,SONIA AGE 34
UNIT # 0023145

symptoms.

Weight Loss-Decreased po intake as likely cause, TSH=wnl, Pt wiht abnrml PAP in past but S/P LEEP and with close GYN follow up.
-Pt couseled on diet
-Megace started today
-Emphasized role of depression/anxiety/PTSD Rx in solution to this problem.

FOLLOW UP-Patient to call in 2 weeks with evaluation of improvement on Megace

GEOFFREY S. GILMARTIN, MD

Cosignature: GILA KRIEGEL, M.D.

Beth Israel Deaconess Medical Center/Healthcare Associates
Psychiatry
330 Brookline Avenue, Boston,MA 02215
INITIAL NOTE Page 1

Date: 07/11/00 Signed: 07/30/00

FERNANDEZ,SONIA AGE 34
UNIT # 0023145

Medications before July 11, 2000:

CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and every day as needed for anxiety
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day

No medications DC'd on July 11, 2000.

Medications prescribed on July 11, 2000:

CLONAZEPAM 500 MCG--One tablet each bedtime
REMERON 15MG--One by mouth each evening

OMR and confidentiality reviewed with the patient.

HPI: The patient is a 34-year-old Hispanic female with a history of insomnia for 4-5 years and panic attacks for the past 2 years who has been treated by her PCP, Dr. Gilmartin, with Klonopin. Patient was referred for further psychopharmacological evaluation of her symptoms and treatment. Patient states that since beginning the Klonopin that it has helped her to be able to fall asleep and has decreased the frequency of her panic attacks to approximately to one every 3-4 weeks. Patient dates her problems with insomnia back to the time she began to work as a police officer in Chelsea approximately 4-5 years ago. Patient dates her panic attacks to approximately 2 years ago with no clear precipitants. Patient endorses multiple depressive symptoms including decreased appetite, decreased energy, decreased concentration. She endorses feeling both helpless and hopeless. She has decreased pleasure. When asked to describe her mood, she states "I don't want to go to work anymore". Patient is currently denying any suicidal or homicidal ideation.

Past Psych History: The patient states that she was treated by a psychotherapist at the East Boston Health Center for approximately one year and the treatment ended when her therapist left the health center. Patient has no history of any psychiatric admission, seizures, or suicide attempts.

Family Psych History: Patient states that both her mother and sister struggle with both symptoms of anxiety and possibly panic.

Substance History: Patient denies any history of substance abuse. States that she does use noncaffeinated coffee, but drinks Mountain Dew and tries to limit her use to one glass per day.

PMH: Patient is s/p MVA approximately 10 years ago, which

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resulted in possible brief loss of consciousness, but no hospitalization. Additionally, the patient has decreased hearing in each ear which has been attributed to lead paint ingestion as a child. The left ear has a greater hearing loss than the right. Patient has a long history of difficulty with gaining weight. She currently states that she weigh 95 lbs and is 5 foot 2 tall. Denies any history of restricting intake or excessive exercise.

Allergies: Patient has no known drug allergies. Although she states that ibuprofen precipitates gastric distress.

Medications: The patient is taking Klonopin .5 mg q.h.s.

Social History: The patient was born in Boston and lived in a family with her mother. Patient's father left the family when the patient was 5 years old and the patient is the oldest of 3 children. Patient attended Chelsea High School. She dropped out of high school and later obtained her GED. She obtained an associates degree from Bunker Hill College and is currently enrolled in Western New England College to obtain a BA degree. Patient has worked as a police offers for 5 years. She has 3 children, ages 16, 14 and 10. Her 16-year-old son is the father of a 6 month old son. Patient is involved in caring for her grandson although the grandson does not lived with the patient and her son.

Mental Status: The patient is a pleasant, engaging, anxious appearing female whose speech is RRR. No abnormal movements were noted. She makes good eye contact. She does have multiple symptoms of depression, please see HPI for details. Patient denies suicidal or homicidal ideation. Patient's thoughts are linear. She endorses no history of psychotic thought content. Denying auditory and visual hallucinations as well as paranoid ideations. Her cognition was grossly intact.

Assessment: This is a 34-year-old Hispanic female who has a history of insomnia and panic and is presenting with depressive symptoms that meet criteria for major depression. Patient has had a previous trial of Celexa which was begun at 20 mg and precipitated significant headaches such that the patient discontinued use of the medication. Patient also has had a trial of Remeron which she did not find find helpful, but did not produce any side effects. The records for the trial of Remeron are apparently in East Boston, as they are not on the OMR. Patient receptive to referral for psychotherapy and receptive to new trial of Remeron since we did not know her previous dose, but did not produce side effects. Remeron may be helpful not only in treating the patient's depression, but frequently has weight gain as a side effect.

Diagnosis:
Axis I: Major depressive disorder, single episode, 296.2.
Panic disorder without agoraphobia, 300.01. Rule out

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adjustment disorder with mixed features of depression and anxiety. Rule out PTSD.
Axis II: Deferred.
Axis III: Please see PMH.
Axis IV: Job stress, 6 month old grandson.
Axis V: 65.

Plan:

1. DEPRESSION

Begin trial of Remeron 15 mg p.o., q.h.s. Will monitor for side effects and increase the dose as the patient is able to tolerate. Referral to psychotherapy made to Elsie Parrilla, LICSW.

2. PANIC DISORDER

Continue Klonopin at .5 mg p.o., q.h.s. Continue to monitor symptoms.

3. INSOMNIA

Continue Klonopin .5 mg p.o., q.h.s. and continue Remeron at 15 mg p.o., q.h.s. Continue to monitor symptoms.

Plan to see the patient in 2 weeks.

DARLENE MILLMAN, M.D.

Beth Israel Deaconess Medical Center/Healthcare Associates
Psychiatry
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PROGRESS NOTE Page 1

Date: 02/12/01 Signed: 03/06/01

AGE 35
FERNANDEZ,SONIA UNIT # 0023145

Patient saw me 7/11/00 for an initial note and did not follow up after that initial appointment. Patient had been referred to Elsie Parrilla, LICSW for social work and scheduled an appointment, but did not follow up. Patient, in July, was tried on a trial of Remeron 15 mg. Patient did not tolerate the medicine and discontinued the medicine shortly after beginning the trial. Has not been in contact with me since this past July.

Subjective: Patient states that the situation at work has worsened. She is feeling alienated from her coworkers, patient described recurrence of symptoms of panic and feeling increasingly depressed.

Objective (mental status): Patient currently endorsing multiple symptoms of depression including irritability, tearfulness, hopelessness. Patient describes her mood as sad. She reports decreased concentration and decreased energy. Her sleep is impaired at times. Her appetite has actually improved since discontinuing smoking. Patient endorses passive suicidal ideation i.e. "I feel like running away", but denies any plan or intent to harm herself or others. Patient endorses panic episodes which are made better with clonazepam.

Assessment: This is a 35-year-old Hispanic female who has a history of insomnia, panic and is presenting after the seven month absence with worsening symptoms of anxiety and depression. She was reported to have had headaches when trial of Celexa was previously tried, the trial was begun at 20 mg. This may have been a dose that was too high for the patient to be able to tolerate. Recommended trial of Celexa at 10 mg q.h.s. Continuing clonazepam at .5 mg. Recommended referral to Elsie Parrilla, LICSW for psychotherapy.

Diagnosis:

Axis I: Major depressive disorder, recurrent 296.3. Panic disorder without agoraphobia 300.01; rule out adjustment disorder with mixed features of depression and anxiety and rule out PTSD.
Axis II: Deferred.
Axis III: Bilateral hearing loss secondary to history of lead paint, history of difficulty gaining weight.
Axis IV: Job stress. Multiple roles as mother, grandmother as well as coworker.
Axis V: 65.

Plan:

1. DEPRESSION

Begin trial of Celexa 10 mg p.o., q.h.s. Referral to Elsie

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FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Parrilla, LICSW for support of psychotherapy.

2. PANIC DISORDER

Continue Klonopin at .5 mg p.o., q.h.s. Continue to monitor symptoms. Begin Celexa.

3. INSOMNIA

Continue clonazepam .5 mg p.o., q.h.s. See the patient in four weeks.

DARLENE MILLMAN, M.D.

March 23, 2001

RE: Sonia Fernandez (002-31-45)

Dear To Whom It May Conern:

At the request of the patient, I am summarizing her treatment with me to date. Further details of the treatment can be obtained from a copy of the medical record.

Ms. Sonia Fernandez met with me twice. Her initial appointment was on July 11, 2000, at which time she was diagnosed with Major Depressive Disorder, single episode, 296.2 and Panic Disorder without agoraphobia, 300.01. Her second appointment with me was on February 12, 2001 at which time which still met criteria for Major Depressive Disorder and Panic Disorder without agoraphobia. The patient was prescribed an anti-depressant at each visit and referred to a social worker for psychotherapy.

Sincerely,

Darlene Millman, M.D.

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PROGRESS NOTE Page 1

Date: 03/28/01 Signed: 04/02/01 Cosigned: 04/12/01

AGE 35

FERNANDEZ,SONIA UNIT # 0023145

Medications before March 28, 2001:

CELEXA 20MG--Take one-half tablet at bedtime
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One tablet each bedtime
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day

Medications DC'd on March 28, 2001:

CLEOCIN T 1%--During reorder
CLONAZEPAM 500 MCG--During reorder

No medications prescribed on March 28, 2001.

Patient is a 35 y.o. female, who comes for f/u on multiple issues.

1. The patient continues with insomnia, weight loss, anxiety and depressive symptoms. Her weight has gone down from 101.2 to 99.2. She states that she is taking 2 Klonopin at bedtime, but is still unable to sleep through the night. She is having difficulty at work and is in the middle of legal proceedings against the Revere Police Department. She is reluctant to go back to work. She is seeing Dr. Millman as well as a social worker for help with this. She continues on Celexa 10 mg po q.d. as well as Klonopin .5 mg q h.s. Patient to f/u with social worker today and Dr. Millman in the next 1 month.

2. Patient's breast lumps have been completely asymptomatic. She does not feel breast lumps at all at this point. Her ultrasound and mammogram were negative and f/u to the Breast Clinic yielded no further work-up. At this point, patient was instructed to continue to monitor her breasts.

3. In terms of health maintenance, patient's blood pressure was checked today and was 92/60. Her cholesterol done in 9/00 was 157 with HDL of 64. Her Ob/Gyn/Pap exam was done on 2/01 by Dr. Yum with a negative Pap smear and she has no family history of colon cancer so a colon surveillance will not need to be performed for ~15 years.

Patient was instructed to f/u with me as needed. Will continue to discuss with Dr. Millman and patient the need for leave of absence from work and further psychiatric treatment for anxiety and depression.

JASON MEROLA, MD

Cosignature: LEONOR FERNANDEZ, M.D.

March 29, 2001

RE: Sonia Fernandez (002-31-45)

Dear Mayor Thomas Ambrosino:

Ms. Fernandez was in for follow-up yesterday afternoon and appeared to be in significant distress emotionally, suffering both from anxiety as well as depression. She reports that her concentration is significantly diminished, and that she is having intermittent anxiety attacks.

Although I am not a psychiatrist, it appears at the present time that she would be ineffective at her job (as a police officer) due to her depression and anxiety. I cannot prognosticate as to the duration of continued symptoms, nor the best treatment options. I do, however, feel that it would be in her best medical interest to avoid returning to work (ie. to be granted a leave of absence) until she can be evaluated again by her psychiatrist, Dr. Millman. This should occur in the next 1-2 weeks.

Please call 667-9600 with any questions.

Sincerely,

Jason Merola, MD

[SOURCE: OMR]

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INITIAL NOTE Page 1

Date: 04/03/01 Signed: 04/10/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Medications before April 3, 2001:

CELEXA 20MG--Take one-half tablet at bedtime
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One tablet each bedtime
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day

No medications DC'd on April 3, 2001.

No medications prescribed on April 3, 2001.

Since patient did not keep this appointment I decided to dictate what I have from a partial evaluation:

This is a partial initial note.

Patient confidentiality and information were thoroughly discussed.

ID: A 35-year-old Puerto Rican American woman, single mother of three children. Patient works as a police officer in the city of Revere. Patient lives in the city of Revere with her children in a house they own.

Patient was referred by Darlene Millman psychiatrist from the North Suite at HCA to have patient psychosocially evaluated.

PRESENTING PROBLEM: "I am a police officer in the city of Revere and I have been harrassed because of my poor hearing, my gender and race." "I wondered, do I take it or do I go to MCAD (Mass Commission Against Discrimination)?" "I decided would take a stance not to be a victim anymore." Patient states that she is the sole provider for all of her children and had to weigh her career and family when she made this decision. She said that in the past she had not decided to go to MCAD to file for discrimination because she felt compelled to take care of her family which has been her priority. Patient reports that a series of incidents have caused her quite a bit of distress which include the hanging of a set of panties on the clip board of the police station where she works. Patient is the only Latino police officer that works there. Patient states that the leutenant said that no matter what nationality patient was, "all [Latinos] were still considered cockroaches". Patient said that increasingly she felt uncomfortable, felt alienated and started to feel that she was being made part of the police force. Patient

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FERNANDEZ,SONIA AGE 35
UNIT # 0023145

would like to return to work as a police officer and wonders what her options are.

SYMPTOMS: Patient reports a recurrence of panic attacks, constant crying, increased anxiety, increased isolation despite having a supportive and present family and increased sadness. Patient is not eating well, has decreased appetite, insomnia with ruminating thoughts about what she is going to do, accompanied by weight loss of 4 lbs in one week (patient is eating one meal a day, not drinking water w/limited hydration). Patient reports that she is also having nausea which at times may cause her to vomit.

PSYCH HISTORY: Patient saw Nancy Ironoff, LICSW at the East Boston Health Center some years ago. She couldn't recall which years exactly in the juncture of a break up of a relationship from her ex-boyfriend, problems with her children and problems with work. Patient's experience of this treatment was helpful in that it "helped me put things in a different perspective." When patient tried to seek this therapist out, she found out that she was no longer working at East Boston.

MEDICAL HISTORY: Patient has ulcers for which she takes Zantac. Had the surgery of cervical cancer which no longer is a problems. History of severe migraines, tension headaches, never has been unconscious, doesn't smoke cigarettes, periodically drinks coffee.

FAMILY HISTORY: The patient is the oldest of three children born in Revere, MA. At the age of 5, the parents separated due to domestic violance and father's ongoing infidelities. Between the age of 8 and 9, mother re-married and produced patient's two siblings. During the course of that relationship, her stepfather started abusing drugs. No further information is available.

DEVELOPMENTAL HISTORY: Not available.

SOCIAL HISTORY: Patient works as a police officer.

SUBSTANCE ABUSE HISTORY: Not assessed.

MENTAL STATUS EXAM: Affect was anxious and sad w/constricted range. Reports ongoing episodes of panic attacks. Mood was somewhat despondant. Appearance was neat. Patient was engaging and slightly guarded. Good eye contact. Speech rhythm at times was pressured with goal oriented content. She was oriented x 3. Memory and concentration were not fully assessed, but patient complained of memory and concentration problems. Patient was not

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FERNANDEZ,SONIA AGE 35
UNIT # 0023145

homicidal, suicidal or psychotic. Her judgement was fair. Intelligence nor assessed.

FORMULATION: This is a 35-year-old Puerto Rican American single mother of three who is a police officer coping with the results of having been harrassed at work. Patient wishes to be able to have some time to get better and stabilize herself emotionally in order to move on. Is hoping that psychotherapy will help her with this process.

DIAGNOSIS:

Axis I: 300.01 & 309.28.
Axis II: 799.9.
Axis III: Headaches.
Axis IV: Harrassment at work; familial problems; filing at MCAD; leaving work at this time.
Axis V: Current GAF is 55, highest GAF last 12 months probably 75 to 80.

TREATMENT PLAN:

1. SOME DEPRESSION

Goal: Decrease depressive symptoms.

Intervention: Psychopharmacology. To do psychotherapy in order to help patient find other ways of managing her depressive symptoms as well as compliant with antidepressant medicaiton.

2. HARRASSMENT AT WORK

Goal: Help patient provide support to manage the upcoming court proceedings.

Intervention: Supportive psychotherapy.

Estimated length of treatment and frequency, I will see this patient once to twice every two weeks for two months at which time treatment will be reviewed.

ELSIE PARRILLA, L.I.C.S.W.

[SOURCE: OMR]

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PROGRESS NOTE Page 1

Date: 04/10/01 Signed: 04/30/01

AGE 35
FERNANDEZ,SONIA UNIT # 0023145

Medications before April 10, 2001:

CELEXA 20MG--Take one-half tablet at bedtime
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One tablet each bedtime
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day

No medications DC'd on April 10, 2001.

Medications prescribed on April 10, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly

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Diagnosis: 309.28, rule out 300.01.

This is a 50 minute individual psychotherapy session attended into this session by Sonia Fernandez.

S: "I didn't want to miss any appointments but I did because of family demands".

O/A: Patient continues to struggle with side effects from antidepressant medications. Is concerned about the ongoing episodes of panic. Would like to get something for relief. Also complained of problems sleeping. She feels quite overwhelmed with phone calls she is receiving from people who seemingly are not happy with her filing discrimination charges through MCAD for investigation.

Mental Status Exam: Patient was highly anxious and overwhelmed. Her mod was of concern for the well-being of her family. She does report episodes of panic attacks. Speech, at times is pressured, though the content seemingly is goal oriented. Patient is not suicidal, homicidal or psychotic. Her judgement is good.

Plan:

1. For patient to continue individual psychotherapy.
2. For patient to continue discussion about taking psychotropic medications as prescribed.
3. Continue to provide support as patient goes through a process that is anxiety provoking to her.

Next appointment is scheduled for 4/24 at 10 a.m.

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Date: 04/10/01 Signed: 04/30/01

FERNANDEZ, SONIA AGE 35
UNIT # 0023145

ELSIE PARRILLA, L.I.C.S.W.

[SOURCE: OMR]

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PROGRESS NOTE Page 1

Date: 04/30/01 Signed: 06/06/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Medications before April 30, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
CLEOCIN T 1%--Apply to face twice a day as needed
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day

No medications DC'd on April 30, 2001.

No medications prescribed on April 30, 2001.

VS: Wt. 100 lbs BP 100/78 T 97.9

Diagnosis: 309.28.

This is a 50 minute individual psychotherapy session attended punctually by Sonia Fernandez.

S: "I still get panic attacks and don't feel better".

O/A: Patient is dealing with psychosocial stressors which include finances because she is getting no income and having the responsibility of her children. She is planning to possibly sell her home to make ends meet. Is concerned about going back to the job where she was allegedly discriminated against.

Mental Status Exam: Patient was highly anxious and overwhelmed with circumstances at work. Continues to have disturbance in sleep and is concerned about the security of her family. Patient had good eye contact. Speech, rhythm and rate were sometimes pressured and the content at times was tangential and at other times circumstantial, but at the same time was goal oriented during certain periods of times. Her judgement is fair.

Plan: To remain the same. Next appointment is scheduled for 5/14 at 10:10 a.m.

ELSIE PARRILLA, L.I.C.S.W.

[SOURCE: OMR]

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General Medicine/Primary Care
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PROGRESS NOTE Page 1

Date: 05/09/01 Signed: 05/21/01 Cosigned: 06/27/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Medications before May 9, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
CELEXA 20MG--Take one-half tablet at bedtime
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One tablet each bedtime
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day

Medications DC'd on May 9, 2001:

CLONAZEPAM 500 MCG--During reorder

Medications prescribed on May 9, 2001:

CLONAZEPAM 500 MCG--One by mouth at bedtime and one by mouth q 12hrs as needed for anxiety
ZYRTEC 10MG--Take one by mouth every day

VS: Wt. 103 lbs

Patient is a 35 y.o. female, who comes for f/u of depression and complaints of allergic rhinitis. Patient states that she is feeling much better since her leave of absence was approved by the mayor of Revere. She is currently looking for a new job and has a law suit pending. She is otherwise feeling well and sleeping better. She is gaining weight and now is 100 lbs. She is eating and concentrating much better. She is currently seeing Dr. Millman as well as a social worker on a regular basis. She reports that she has had a diminished stooling. When I last talked with her, she saw Dr. Charles Lee, who felt this is an irritable bowel syndrome. However, checked a TSH and free T4 which were on further review normal.

She is currently complaining of allergic symptoms including runny eyes, runny nose, sore throat and postnasal drip. She says that she has had this yearly for several years, but has not done anything about it.

Patient is likely suffering from allergic rhinitis. Will prescribe Zyrtec 10 mg po q.d. and f/u with me in 6 weeks time. Patient will continue to see social worker and Dr. Millman for treatment of anxiety and depression. Klonopin refill today.

JASON MEROLA, MD

Cosignature: LEONOR FERNANDEZ, M.D.
[SOURCE: OMR]

Beth Israel Deaconess Medical Center/Healthcare Associates
Psychiatry
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 1

Date: 05/21/01 Signed: 07/11/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Medications before May 21, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
CELEXA 20MG--Take one-half tablet at bedtime
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and one by mouth q 12hrs as needed for anxiety
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
ZANTAC 150MG--Take on by mouth twice a day
ZYRTEC 10MG--Take one by mouth every day

Medications DC'd on May 21, 2001:

CELEXA 20MG--Patient discontinued because of headaches

Medications prescribed on May 21, 2001:

PAXIL 10MG--One by mouth each night

Subjective: Patient states that she discontinued previous trial of Celexa because of headaches. States that she is on unpaid leave of absence from her job and feels that her symptoms have not improved.

Objective (mental status): Patient currently endorsing multiple symptoms of depression including irritability, tearfulness and helplessness. Patient described her mood as sad. Decreased concentration and decreased energy. Her sleep is impaired at times. Appetite is actually improved since discontinuing smoking. Patient endorses passive suicidal ideation without any plan or intent. Patient endorses panic episodes which are made better with clonazepam.

Assessment: This is a 35-year-old Hispanic female who has a history of insomnia and panic who is presenting after discontinuing a trial of Celexa as well as previous trial of Remeron. Patient requesting trial of Paxil (patient's brother in law has been taking Paxil). Patient would benefit from a trial of an antidepressant which will help not only with depressive symptoms as well as panic. Agreed to a trial of Paxil at 10 mg. Patient presented me with a form to be completed at the end of the session regarding disability. Suggested that the patient present this form to her psychotherapist, Elsie Parrilla, LICSW for consideration. I will be happy to be involved in collaborating with the patient as well as her therapist regarding what is clinically indicated.

Beth Israel Deaconess Medical Center/Healthcare Associates
Psychiatry
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 2

Date: 05/21/01 Signed: 07/11/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Diagnosis:

Axis I: Major depressive disorder, recurrent 296.3. Panic disorder without agoraphobia, 300.01, rule out adjustment disorder with mixed features of depression and anxiety, rule out PTSD.
Axis II: Deferred.
Axis III: Bilateral hearing loss secondary to history of lead paint, history of difficulty gaining weight.
Axis IV: Financial problems.
Axis V: 65.

Plan:

1. DEPRESSION

Begin trial of Paxil 10 mg p.o., q.h.s. Patient to continue psychotherapy with Elsie Parrilla, LICSW.

2. PANIC DISORDER

Continue clonazepam as prescribed by patient's PCP. Continue to monitor symptoms. Begin Paxil.

3. INSOMNIA

Continue clonazepam as well as Paxil. See the patient in eight weeks.

DARLENE MILLMAN, M.D.

[SOURCE: OMR]

Beth Israel Deaconess Medical Center/Healthcare Associates
Psychiatry
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 1

Date: 05/31/01 Signed: 06/06/01

FERNANDEZ,SONIA AGE 35
UNIT # 0023145

Medications before May 31, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and one by mouth q 12hrs as needed for anxiety
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
PAXIL 10MG--One by mouth each night
ZANTAC 150MG--Take on by mouth twice a day
ZYRTEC 10MG--Take one by mouth every day

No medications DC'd on May 31, 2001.

No medications prescribed on May 31, 2001.

Diagnosis: 309.28, 300.05.

This is a 50 minute individual psychotherapy session attended 30 minutes into the session by this patient who called me from her cell phone while in heavy traffic.

S: "I'm looking for work".

Patient is becoming increasingly anxious about not being able to get a paying job. Is concerned about her finances and her capacity to support her family. She is borrowing money from her family members and friends to get by. Has gone through three interviews and hopes to be able to find gainful employment. Is thinking about leaving the police force. At the end of the session she requested for me to to sign a document needed to be filled out to establish her disability. The document asked for a physician's signature. Patient was referred back to her physician.

Mental Status: Patient seemed less anxious and less depressed than previous sessions. She is hoping that she can get gainful employment though is anxious about not being able to be hired soon enough to support her family. She is not homicidal, suicidal or psychotic. Judgement is good. Concentration and memory seemed relatively intact.

Plan: To remain the same. Next appointment is scheduled for 6/19 at 10 a.m.

ELSIE PARRILLA, L.I.C.S.W.

[SOURCE: OMR]

Beth Israel Deaconess Medical Center/Healthcare Associates
General Medicine/Primary Care
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 1

Date: 10/31/01 Signed: 11/25/01 Cosigned: 11/28/01

FERNANDEZ,SONIA AGE 36
UNIT # 0023145

Medications before October 31, 2001:

ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and one by mouth q 12hrs as needed for anxiety
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
PAXIL 10MG--One by mouth each night
ZANTAC 150MG--Take on by mouth twice a day
ZYRTEC 10MG--Take one by mouth every day

Medications DC'd on October 31, 2001:

CLEOCIN T 1%--During reorder
CLONAZEPAM 500 MCG--During reorder

Medications prescribed on October 31, 2001:

AMBIEN 5MG--Take one by mouth at bedtime of sleep

VS: Wt. 103.2 lbs

The patient is a 36 year old female who comes in for f/u of her depression.

The patient is feeling much better now. She has taken several months off and now returns to work ??October 1st after therapy with Dr. Millman as well as with Social Work. The patient is feeling much better. She has gained approximately seven pounds from her lowest weight. She says that she is eating better. She is not having problems with concentration or energy. She is continuing to have difficulty sleeping. The patient says that she, several nights ago, had an episode of her heart pounding while she was lying in bed. She felt slightly anxious and took a Klonopin, and after an hour or so, took another Klonopin because of her anxiety level. She says the heart-thumping resolved within an hour or two. She did not have light-headedness, dizziness, or other chest pain associated with the heart-pounding.

Physical Examination:
VS: HR: 84, BP: 110/78.
General: Well-appearing, no acute distress.
HEENT: PERRL. EOMs full. Sclerae: white. Oropharynx: w/o lesion. Neck: supple, no JVD, no lymphadenopathy.

Beth Israel Deaconess Medical Center/Healthcare Associates
General Medicine/Primary Care
330 Brookline Avenue, Boston,MA 02215
PROGRESS NOTE Page 2

Date: 10/31/01 Signed: 11/25/01 Cosigned: 11/28/01

FERNANDEZ,SONIA AGE 36
UNIT # 0023145

COR: regular rate and rhythm, normal S1/S2, no murmurs, rubs, or gallops.
Lungs: clear to auscultation bilaterally.
Abdomen: soft, nontender, nondistended, good bowel sounds.
Extremities: w/o cyanosis, clubbing, or edema.

Assessment and Plan:

Thirty-six year old female with the following issues:

1) DEPRESSION / ANXIETY

The patient seems to be improved after her time off and therapy with a psychiatrist and Social Work psychotherapy. The patient is to continue Klonopin and Social Work psychotherapy f/u. The patient is to return to work ??October 1st; we will see how this goes. The patient has been given a sleeping pill, Ambien, 5 mg to be taken q.h.s., to help with sleep issues. Her shifts at the Revere Police Department are awkward for sleeping regularly.

2) HEART THUMPING

I feel this is related to anxiety and increased awareness of her heart. I do not feel this is related to any cardiovascular abnormality or tachy- or bradyarrhythmia. The patient was instructed that the next time this happens to take her heart rate at her wrist and to call me with the results. If there is evidence of tachycardia, will perform an EKG and potential King of Hearts monitor.

3) HEALTH MAINTENANCE

The patient's Pap smear and breast examination/mammogram are up to date. Her cholesterol was previously checked and was normal. Her blood pressure was as marked above.

The patient will f/u in 6-12 months' time.

JASON MEROLA, MD

Cosignature: JENNY J LIN, MD

[SOURCE: OMR]

Beth Israel Deaconess Medical Center/Healthcare Associates
General Medicine/Primary Care
330 Brookline Ave., Boston,MA 02215
PROGRESS NOTE Page 1

Date: 12/27/01 Signed: 12/27/01 Cosigned: 12/29/01

FERNANDEZ,SONIA AGE 36
UNIT # 0023145

NAUSEA / ANXIETY

Medications before December 27, 2001:

AMBIEN 5MG--Take one by mouth at bedtime of sleep
ANUSOL-HC 1%--Use as directed twice a day as needed for hemorrhoid, use sparingly
ATARAX 25MG--Take one tablet (up to 4 times per day) as needed for itching
CLEOCIN T 1%--Apply to face twice a day as needed
CLONAZEPAM 500 MCG--One by mouth at bedtime and one by mouth q 12hrs as needed for anxiety
MEGACE 20MG--One by mouth every day
MEGACE 40MG--One by mouth every day
NAPROSYN 500MG--One twice a day with food
PAXIL 10MG--One by mouth each night
SYNALAR 0.01%--Apply to affected areas, except face, twice per day
ZANTAC 150MG--Take on by mouth twice a day
ZYRTEC 10MG--Take one by mouth every day

No medications DC'd on December 27, 2001.

Medications prescribed on December 27, 2001:

ATIVAN 1MG--One tablet three times a day as needed for anxiety or nausea

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36 yo F, with hx anxiety, panic attacks, depression, ? GERD, presents as EPI visit with c/o nausea x one week in setting of increased anxiety and depression, which she relates to stresses at work as a police officer. She believes that her nausea is being caused by her anxiety. She reports having vomitted twice a few days ago, without any blood. She aslo reports diarrhea 3-4 x per day, but this is chronic for her, carrying a diagnosis of irritable bowel syndrome. She denies BRBPR, melena, abd pain, polyuria or dysuria. She is not sexually active and is currently menstruating. She is also s/p tubal ligation.

She has been followed by Dr. Millman of psychiatry in the past, but she has not followed up and is requesting a new psychiatrist. She has not been taking her Klonopin regularly since it would interfere with her work as a police officer. Previously, she stopped taking Paxil secondary to headaches. Today, she c/o depression, crying spells, and anxiety accompanied by nausea and occasional vomiting. She states that she owns a gun for work, but unequivocably states that she has no suicidal or homocidal ideation.

Meds include Klonopin 0.5 mg BID PRN, Zantac, and Ambien

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General Medicine/Primary Care
330 Brookline Ave., Boston,MA 02215
PROGRESS NOTE Page 2

Date: 12/27/01 Signed: 12/27/01 Cosigned: 12/29/01

AGE 36

FERNANDEZ,SONIA UNIT # 0023145

All: NKDA

Exam:
VS: Weight 103 lbs, BP 118/80, Temp 98.1, HR 96
Gen: thin, pale, depressed affect, NAD
HEENT: MMM
Cor: RRR, s1s2, no m
Pulm: CTAB
Abd: Soft, NTND
Ext: no C/c/e
Psych: depressed mood, no SI

Labs: urine dipstick- normal

Impression:
I suspect her nausea is in part secondary to her anxiety and depression. I viral process such as gastroenteritis is also possible given the diarrhea, but it seems like this is more of a chronic process for her. From a psych standpoint, she is clearly depressed and anxious, but appears to be stable with no SI or HI, although the fact that she owns a gun may become concerning.

Plan:
-I have strongly recommended that she see a psychiatrist and have given her a referral.
-She is currently taking a leave of absence from work.
-Recommended taking Klonopin 0.5 mg BID standing and Ativan 1 mg TID PRN for anxiety and panic. This will also aid with nausea. I have instructed her that both of these medicines cannot be taken while she is working as a police officer in the line of duty as they may make her drowsy or impair her judgment.

Discussed with Dr. Carter

MICHAEL WEIN, MD

Cosignature: J. JACQUES CARTER, M.D.

[SOURCE: OMR]